IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

LAURA BRISCOE, KRISTIN MAGIERSKI, and EMILY ADAMS on behalf of themselves and all others similarly situated, Plaintiffs, v. HEALTH CARE SERVICE CORPORATION and BLUE CROSS AND BLUE SHIELD OF ILLINOIS, Defendants.	)	**No. 1:16-cv-10294** **Honorable John Robert Blakey** **[PUBLIC, REDACTED VERSION]**

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes & Other Authoritiess

I. INTRODUCTION AND SUMMARY OF ARGUMENT

Plaintiffs' renewed Motion for Class Certification[1] presents a tailored set of classes with subclasses and addresses the Court's concerns set forth in its January 21, 2020 Memorandum Opinion and Order Denying Class Certification ("CC Order", Dkt. 138).

First, in discovery, Plaintiffs uncovered that HCSC had a written policy governing its coverage of comprehensive breastfeeding and lactation support services ("CLS"). HCSC's Policy states that CLS services are only eligible for coverage without cost-sharing when provided by a network provider and billed with a limited number of "procedure codes." Plaintiffs' claim is that HCSC's Policy does not comport with the ACA requirement that, for each member of the Classes, HCSC was to, at "a minimum," provide coverage for and not impose any cost sharing requirements for CLS (*see* 42 U.S.C. § 300gg-13(a)(4)). HCSC's Policy, as written, does not comply with the ACA because it limits CLS no-cost coverage eligibility to: (i) in-network CLS claims and (ii) a restricted number of Procedure Codes.[2] HCSC's Policy applied to each CLS claim submitted by each member of the Classes throughout the Class Period.

To be clear, Plaintiffs' Motion is grounded on the fact that HCSC's Policy, as stated, violated the ACA. Plaintiffs' claims and motion for class certification are not based on "varied claims," "numerous theories of liability," or that HCSC "harmed class members in a variety of distinct ways" including with "administrative barriers" or through a "range of allegedly unlawful activity" (*see* CC Order at 8-10, and fn. 3). While those are certainly the egregious *consequences* of HCSC's unlawful Policy, they cannot be conflated with the challenged Policy and are plainly

[1] Exhibits referenced herein are attached to the Donaldson-Smith Declaration ("Ex.") filed concurrently herewith.

[2] HCSC's Procedure Codes are (i) from August 1, 2012 through July 14, 2017, Procedure Codes 99401-99404, 99411-99412, S9443; and, (ii) from July 14, 2017 to present, Procedure Codes S9443, 99401-99404, 99411-99412, 99347-99350.

not applicable to the Rule 23 analysis, notwithstanding any expected, self-serving urging by HCSC. *See e.g. Keegan v. Am. Honda Corp.* 284 F.R.D. 504, 530 (C.D. Cal. 2012) ("defendants repeatedly 'confuse[ ] the defect at issue . . . with the consequences of that defect'…").

Second, Plaintiffs have re-defined the Classes and utilized subclasses to address the Court's concerns about commonality and typicality (*c.f.* CC Order at 10-12). Specifically,

- Insureds who never submitted CLS claims are not included in the Classes (*c.f. id.* at 12).
- Insureds who received in-network CLS and whose CLS claim included one of HCSC's Procedure Codes are not included in the Classes (*c.f. id.* at 10).
- The narrowed set of CLS claims covered by the revised Class definitions include only CLS claims for which HCSC denied or imposed cost-sharing.

In sum, the redefined Classes and Subclasses solely capture (a) the submitted out-of-network CLS claims and (b) submitted CLS claims that did not include one of HCSC's Procedure Codes, for which claims HCSC denied or imposed cost-sharing.

Therefore, the class definitions, class membership, and the relief sought are tailored specifically to the resolution of the question of whether HCSC's Policy, in two respects, violated the ACA mandate for coverage without cost-sharing; those are two significant questions that drive the resolution of the Class' claims. *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011). With the focused class definitions, Plaintiffs now present a direct challenge to the "systemwide" HCSC Policy that governed HCSC's decision to impose cost-sharing specifically on: (a) the out-of-network CLS claims, and (b) any submitted CLS claim that did not include one of HCSC's Procedure Codes. (*See* CC Order, end of pg. 10). Indeed, the ACA requires both coverage and no cost-sharing, and here, Class members suffered the very injury prohibited by the ACA – no coverage and cost-sharing.

Third, commonality and typicality are also satisfied because Plaintiffs do share the same common injuries with the members of the redefined Classes. Plaintiffs hereby address another of the Court's expressed concerns that each named Plaintiff and Class Representative was not injured by HCSC's Policy, *see* CC Order at 10, 11. Specifically, with respect to the HCSC Procedure Codes, each Plaintiff submitted a CLS claim that did not include one of HCSC's restrictive Procedure Codes.[3] And, with respect to the out-of-network claims, each Plaintiff submitted an out-of-network CLS claim. Accordingly, Plaintiffs and the members of the Classes do share a common injury from HCSC's Policy with respect to both (a) the out-of-network CLS claims and (b) HCSC's Procedure Codes. (*C.f.* CC Order at 10-11).

Plaintiffs' and Class members' interests are not antagonistic; instead, they seek a common finding of liability and common, consistent relief including to have HCSC's CLS Policy declared void and in violation of the ACA since August 2012, and to enjoin its use. Likewise, Plaintiffs are advancing two standard conducts of practice that affect the Classes, warranting a finding of commonality. *Holmes v. Godinez*, 311 F.R.D. 177, 217-20 (N.D. Ill. 2015); *A.F. ex rel. Legaard v. Providence Health Plan*, 300 F.R.D. 474, 481 (D. Or. 2013).

Fourth, the proposed Class members are appropriately "ascertainable." (*C.f.* CC Order at 11). As an initial, critical point, however, Plaintiffs need not demonstrate "ascertainability." Plaintiffs sought and again seek certification under Rule 23(b)(2), not Rule 23(b)(3). Rule 23(b)(3) sets forth the predominance and superiority elements that may underly considerations of the ascertainability of the members of the classes. Rule 23(b)(2) does not require the same demonstration or finding as a prerequisite to certification. Even if a demonstration of

[3] *See* Exhibits 2, 27 and 22 (Adams' and Magierski's claims used procedure code 99343, and Briscoe's claim used procedure code 96150, neither of which are one of HCSC's Procedure Codes).

ascertainability were required, and it is not, the analysis would have to be consistent with the Seventh Circuit's (along with at least the Second, Sixth, Eighth and Ninth Circuits) refusal to adopt a heightened ascertainability requirement. *See e.g.*, *Briseno v. ConAgra Foods, Inc.*, 844 F.3d 1121, 1123, 1126 (9th Cir. 2017)(citing *Mullins v. Direct Digital, LLC*, 795 F.3d 654, 658 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 1161, 194 L. Ed. 2d 175 (2016), and stating that "[T]he language of Rule 23 does not impose a freestanding administrative feasibility prerequisite to class certification. Mindful of the Supreme Court's guidance, we decline to impose an additional hurdle into the class certification process delineated in the enacted Rule."); *see also, e.g.*, *In re Petrobras Sec. Litig.*, 862 F.3d 250, 265 (2d Cir. 2017). Plaintiffs have set forth objective criteria on which class members will be identified: those who submitted a CLS claim to HCSC for which HCSC denied or imposed cost sharing.

Based on the foregoing and as demonstrated herein, this Action is ideally suited for class certification under Fed. R. Civ. P. 23(a) and (b)(1) and (b)(2).

II. FACTS PERTINENT TO CLASS CERTIFICATION

A. The ACA and CLS

This Court has aptly stated that "[a]t summary judgment, the parties can address the precise legal contours of the ACA's coverage requirements." (12/4/17 Order, Dkt. 50, at 13).

It is undisputed that the ACA requires that all non-grandfathered, non-federal health benefit plans "shall, at a minimum provide coverage for and not impose any cost sharing requirements for…" enumerated preventive services. 42 U.S.C. § 300gg-13(a)(4); 29 CFR 2590.715-2713. The term "cost-sharing" "in general" includes "deductibles, co-insurance, copayments, or similar charges…." 42 U.S.C § 18022(c)(3)(A). Insurers cannot circumvent the ACA's mandate by not having in-network providers for preventive services. *See* 29 C.F.R. §

2590.715-2713(a)(3)(i)-(ii). HCSC admits that the ACA requires coverage without cost-shares for preventive care as provided for by HRSA. *See* HCSC Answer, Dkt. 57, at ¶ 4.

On August 1, 2011 and December 20, 2016, pursuant to (a)(4), HRSA adopted and released its guidelines (the "HRSA Guidelines") for "[b]reastfeeding support, supplies, and counseling" which HRSA described as:

- "[c]omprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment" (in 2011, Ex. 10), and
- "[c]omprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding" (in 2016, Ex. 11).[4]

HCSC admits that the HRSA Guidelines are as stated above and included "[b]reastfeeding support, supplies, and counseling," (*see* HCSC Answer, Dkt. 57, at ¶5). The 2011 HRSA Guidelines were based on studies and recommendations of the independent Institute of Medicine ("IOM") (now known as the National Academy of Medicine) as set forth in its report, *Clinical Preventive Services for Women: Closing the Gaps.* (IOM Report excerpts, Ex. 12). The 2016 HRSA Guidelines were based on the Women's Preventive Services Initiative 2016 Final Report ("WPSI Report" excerpts, Ex. 13). As the WPSI Report at 41 confirms, "The gap in services provided under the [ACA provisions] previously identified by [IOM] was that comprehensive prenatal and postnatal lactation support, counseling, and supplies were not included…The IOM recommendation includes an explicit description of a ***more comprehensive set of services***…" (emphasis added). *See also*, Ex. 12, IOM Report at 116.

[4] As this Court concluded in its Dec. 4, 2017 Opinion and Order (Dkt. 50), the "relevant [HRSA] provisions remain substantively the same in the [2016] version." (12/4/17 Order at p. 2 fn. 1).

Further, per the Tri-Departments[5], the ACA expanded preventive services coverage to address "access and utilization of these services," "underutilization of preventive services" due to "market failures" identified as "plans' lack of incentive to invest in these services," and "eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services." Ex. 1, 75 FR 41726 at 41730, Table 1, and at 41731.

B. HCSC and its Challenged Policy

HCSC administers health care plans through its unincorporated divisions, the Blue Cross/Blue Shields of Illinois, Texas, Montana, Oklahoma, and New Mexico (collectively, "HCSC Divisions"), that HCSC admits "are subject to the ACA preventive services requirements, including those pertaining to the ACA-mandated breastfeeding support and counseling services." HCSC Answer, Dkt. 57, at ¶1, fn.*, ¶¶21-22, 72. HCSC made no distinction with respect to its CLS coverage policies between and among its Divisions.[6]

HCSC's CLS Policy was set forth as follows:

- From August 1, 2012 - July 14, 2017, in HCSC's Medical Policy for Preventive Care Services (ADM1001.030). It stated that

[redacted]

See Ex. 19 (Example of ADM1001.030, at pgs. 1-2 (Janulis Dep. Ex. 7)).

[5] "When Congress enacted the ACA it ceded broad authority to [the Departments of HHS, Labor, and the Treasury (the "Tri-Departments")] to promulgate rules governing…women's preventive health services in employer-sponsored health plans." *Eternal Word TV Network, Inc. v. Sec'y of the U.S.HHS*, 818 F.3d 1122, 1179 (11th Cir. 2016).

[6] As Stephanie Janulis (an HCSC 30b6 designee) testified, "We don't make the decisions based on each state. We make a decision about the services that are covered for HCSC, and that decision is then equally administered or applied to the state plans." Ex. 3, Janulis Dep Tr. at 23:14-18.

- From July 14, 2017 onward, in the Enterprise Clinical Payment and Coding Policy for Preventive Services (CPCP006). It stated that

[redacted]

See Ex. 20 (Example of the CPCP006, at pages 1 and 17 (Janulis Dep. Ex. 16)).

The "[redacted]"[7] affirm that the ADM1001.030 and then the CPCP006 constituted HCSC's policy for CLS claims eligible for "cost-share-free-coverage" by HCSC, and therefore [redacted] *See* Ex. 14, Janulis 30b6 Doc. at pgs. 1-2 (emphasis added); and, Ex. 16, Benner 30b6 Doc. at pgs. 4-6. Ms. Janulis was not aware of any other document that she would identify as an HCSC policy with respect to CLS coverage that was in effect from August 1, 2012 through the present. *See* Ex. 3, Janulis Dep. Tr. at 174:4-10.

C. The Plaintiffs

Shortly after giving birth,[8] each Plaintiff experienced difficulties breastfeeding.[9] Before receiving CLS services, each Plaintiff made considerable efforts to locate in-network providers of

[7] In response to Plaintiffs' Fed. R. Civ. P. 30(b)(6) Notice, HCSC designated the following witnesses, each of whom came to their depositions with printed notes setting out responses to each of their 30(b)(6) designated Subject Matters: Stephanie Janulis, who, as of approximately April 2019, was HCSC's Director of Clinical Regulatory Oversight for HCSC, and prior to that, from approximately April 2015, HCSC Manager of Care Integration; Marla Ludacka, who has been HCSC's VP of Network Operations since 2016; and Teresa Benner, who as of 2017, was HCSC's Director, Group Member Services, and was prior a HCSC Senior Manager/Manager since 2007. The documents are: "Janulis 30b6 Doc.", Ex. 14; "Ludaka 30b6 Doc.", Ex. 15; and "Benner 30b6 Doc.", Ex. 16.

[8] Briscoe gave birth at home in Chicago, IL in November 2014; Magierski gave birth in April 2016 at Northwest Community Hospital; and Adams gave birth in May 2016 at West Suburban Medical Center.

[9] Briscoe Dep. (Ex. 4) 61:20-62:16 ("I was experiencing such a degree of pain breast feeding" that "it was clear…that I needed to get help if [] I was going to continue breastfeeding); Magierski Dep. (Ex. 5) at 221:19-222:21 (Experiencing issues with latch, engorgement, and cracked and bleeding nipples); Adams Dep. (Ex. 6) at 126:4-22 (Experiencing breastfeeding difficulties and was anxious about her child's "inability to nurse").

CLS by conducting searches on HCSC's Provider Finder Tool and calling HCSC customer service. *See* Exs. 7-9, at Responses No. 2. All three Plaintiffs tried to conduct searches using HCSC's Provider Finder Tool; however, no CLS providers were identified.[10] When each Plaintiff called HCSC's customer service, they were all informed that HCSC had no in-network providers of CLS. *Id.*[11]

Plaintiffs' experiences are consistent with what Plaintiffs uncovered in discovery as the systemic, egregious consequences flowing from HCSC's Policy that out-of-network claims and claims without HCSC's enumerated Procedure Codes were not eligible for cost-share-free CLS coverage.[12] For example, the circularity and futility of HCSC's stance about having thousands of unidentified network providers was not lost on HCSC members, clients, and employees. Ex. 25 at HCSC_0097086 [redacted][13] Indeed, the impact of HCSC's Policy is

[10] *See* Briscoe Dep. (Ex. 4) at 57:4-58:1 ("there was no way to find lactation consultants through the provider finder website…I tried multiple search terms and was never able to find anything"); Magierski Dep. (Ex. 5) at 73:20-74:7 (Magierski could not "find anyone" when searching for lactation consultants, whereas a search using OB/GYN resulted in "a list of hundreds of people… and it wasn't clear [] who was focusing on lactation consulting versus just OB/GYN."); Adams Dep. (Ex. 6) 55:17-56:11; 96:7-24 (Adams was "not able to locate any lactation consultants" because there were "zero results or no results found.")

[11] *See* Briscoe Dep. (Ex. 4) at 91:15-93:5 ("I was specifically asking for in-network lactation consultants and was told that there were none in-network."); Magierski Dep. (Ex. 5) at 70:4-73:17 (customer service representative "said it doesn't appear that there is anyone in the network"); Adams Dep. (Ex. 6) at 55:27-56:11 ("I asked if they had anybody in Illinois that they were contracted with, and they replied no.").

[12] HCSC's [redacted] *See* Ex. 27, [redacted]

[13] As [redacted] *See* Ex. 26 at HCSC_0097043.

shown in its own claims data produced during discovery[14] [redacted]

[redacted].[15]

Each Plaintiff sought and paid out-of-pocket for one-on-one CLS from trained out-of-network providers. *See* Exs. 7-9, at Responses No. 11. Plaintiffs submitted their CLS claims to HCSC, and ultimately each claim had cost-sharing imposed by HCSC: HCSC admits that Plaintiffs Briscoe, Magierski and Adams were, at all relevant times, insured by non-grandfathered BCBSIL plans, and that each was "held responsible" for $40, $245.20, and $125.36, respectively. HCSC Answer, Dkt. 57, at ¶¶ 16-18.[16]

Plaintiffs Adams' and Magierski's claims used procedure code 99343, and Plaintiff's Briscoe's claim used procedure code 96150. *See* Decl. Exhibits 2, 27, 22 (Plaintiffs' claim forms).[17] The codes on Plaintiffs' claim forms are not one of HCSC's Procedure Codes.

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[14] In total, the production contained [redacted] ollectively, the "Claims Data". The spreadsheets and number of data fields comprising the Claims Data [redacted] are voluminous and can only be viewed electronically. Therefore, Plaintiffs do not attach them to their Motion, but can make them available to the Court electronically, under seal, upon request.

[15] The [redacted] claim lines have dates of service from 8-1-2012 through 12-30-2018, and are comprised of: (1) [redacted] in Ms. Peluso's Report (Ex. 18, at Exhibit B, which includes HCSC's Policy procedure codes discussed *supra*) and (b) [redacted] Table 1 in Dr. Hanley's Report (Ex. 21). In addition, [redacted]

[16] All three Plaintiffs appealed, contesting HCSC's coverage determinations. In response to Plaintiff Briscoe's appeal of her initially denied claim, HCSC reprocessed her claim by reflecting that $200 was "covered", but then applied $40 to coinsurance. Meanwhile, HCSC upheld the initial determinations as to Plaintiff Magierski's and Adam's claims leaving them with out-of-pocket expenditures of $245.20 and $125.36, respectively. HCSC Answer, Dkt. 57, at ¶¶ 103, 110, 116-119.

[17] Procedure codes are discussed generally in Ex. 18, Report of Plaintiffs' Expert Nicole Peluso, Dated May 3, 2019, at pgs. 9, 18-20.

III. CLASSES SOUGHT TO BE CERTIFIED AND THE RELIEF SOUGHT

As set forth in Plaintiff's Motion, Plaintiffs seek certification under Rule 23(b)(2) for the ERISA and Non-ERISA Lactation Classes and subclasses, defined identically except for the ERISA reference:

> All persons who were insured by or participants in [ERISA / non-ERISA], non-grandfathered, and non-federal employee health benefit plans insured or administered by HCSC in the United States, who from August 1, 2012 to present received CLS, submitted the CLS claim to HCSC, and HCSC denied or imposed cost-sharing on the CLS claim.
>
> (a) The Out-of-Network CLS Subclass: All members of the [ERISA / Non-ERISA] Lactation Class who received CLS from an out-of-network provider.
>
> (b) The CLS Scope Subclass: All members of the [ERISA / Non-ERISA] Lactation Class who submitted a claim for CLS that did not include one of HCSC's Procedure Codes.

Plaintiffs and the members of the ERISA and Non-ERISA Lactation Classes and subclasses seek declaratory and injunctive relief that includes:

> (1) An order declaring HCSC's Policy that out-of-network CLS claims are not eligible for ACA-mandated preventive care coverage without cost-sharing, to be in violation of the ACA, ERISA and its duties as an insurer / administrator of health plans to provide ACA- compliant plans.
>
> (2) An order declaring HCSC's Policy that CLS claims are not eligible for ACA-mandated preventive care coverage without cost-sharing unless billed with HCSC's Procedure Codes, to be in violation of the ACA, ERISA and its duties as an insurer / administrator of health plans to provide ACA- compliant plans.
>
> (3) An injunction requiring HCSC to revise its Policy (and to any billing, coding or coverage guidance that pertains to CLS used internally or communicated to insureds or providers), to require that out-of-network CLS will be eligible for coverage without cost-sharing as an ACA-mandated preventive benefit.
>
> (4) An injunction requiring HCSC to revise its Policy (and to any billing, coding or coverage guidance that pertains to CLS used internally or communicated to insureds or providers), to require that CLS will be eligible for coverage without cost-sharing as an ACA-mandated preventive benefit when billed with Procedure Codes determined to reflect to the scope of CLS.

> (5) An injunction requiring HCSC to adopt and utilize proper claims procedures for the consideration of CLS claims.
>
> (6) An injunction requiring HCSC to evaluate and process Plaintiffs' and class members' claims under the revised claim procedures for CLS claims; and
>
> (7) An injunction requiring HCSC to provide notice to all class members of the processing and evaluation of out-of-network CLS claims under a proper claims procedure.

Under Federal Rule of Civil Procedure 23(b)(2), Courts routinely certify classes seeking injunctive and declaratory relief that includes, among other things, an injunction requiring health plans, specifically, like HCSC here, to (1) adopt a new standard for processing claims, and then (2) "reprocess" past denied claims for health benefits under that new standard. In *Wit v. United Behavioral Health*, 317 F.R.D. 106 (N.D. Cal. 2016), the plaintiffs also sought a reprocessing injunction, which the court certified under Rule 23(b)(2), holding that "the Plaintiffs' injury can be remedied for all class members by requiring [the plan] to modify its Guidelines and reprocess claims that were denied under the allegedly defective guidelines." In *Trujillo, et al. v. UnitedHealth Group, Inc., et al.*, 17-cv-2547, 2019 U.S. Dist. LEXIS 21927 *9-10 (C.D. Cal. Feb. 4, 2019), the court certified a Rule 23 (b)(2) class because, "Plaintiffs and the class members seek declaratory and injunctive relief that includes…:

> (1) '[a]n order declaring that United's denials of claims…without adequate notices of adverse benefit determination as required by ERISA;' (2) '[a]n injunction requiring United to revise the language of [the] CDG…;' (3) '[a]n injunction requiring United to adopt and utilize proper claims procedures …;' (4) '[a]n injunction requiring United to reevaluate and reprocess Plaintiffs' and class members' claims under revised procedures compliant with the provisions of ERISA;' and (5) '[a]n injunction requiring United to provide notice to all class members of the reevaluation and reprocessing in the form and manner required by ERISA.'

In *Des Roches v. California Physicians' Service*, 320 F.R.D. 486, 497-98, 508 (N.D. Cal. 2017) the court certified a class under Rules 23(b)(1)(A) and 23(b)(2) holding that where a plan

administrator with discretion to construe plan terms misconstrues a term, the court should "remand the claim to the administrator for it to make that decision under the plan, *properly construed*." *Id*. at 456 (emphasis added). Thus, the court continued, "*far from being improper retrospective relief, the reprocessing injunction that Plaintiffs seek is precisely the sort of final relief that the Court should order* ..." *Id.* at 508 (emphasis added).

Accordingly, there should be no concern that the relief sought is proper and tailored specifically to the resolution of the question of whether HCSC's Policy, in two respects, violated the ACA mandate for coverage without cost-sharing; those are two significant questions that drive the resolution of the Class' claims. *Wal-Mart*, 564 U.S. at 350. *See also, e.g., Laurent v. PricewaterhouseCoopers LLP*, No. 18-cv-487, 2019 U.S. App. LEXIS 38178, at *3-4 (2d Cir. Dec. 23, 2019), petition for rehearing denied on Feb. 12, 2020, in which the Second Circuit held that, even under ERISA section 502(a)(1)(B), which allows participants to bring actions to recover benefits or clarify rights to future benefits due "under the terms of the plan" "reformation of the plan and the recalculation of benefits in accordance with the reformed plan" is an equitable ERISA remedy.

IV. CERTIFICATION OF THE CLASSES AND SUBCLASSES IS PROPER

In conducting the Rule 23 analysis, "the court should not turn the class certification proceedings into a dress rehearsal for the trial on the merits." *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 811 (7th Cir. 2012); *Magpayo v. Advocate Health & Hosps. Corp.*, No. 16-cv-01176, 2018 U.S. Dist. LEXIS 26282, at *7 (N.D. Ill. Feb. 20, 2018) (Blakey, J.) (citing *Messner*). While Plaintiffs must show that a proposed class satisfies the Rule 23 requirements, the showing need not be made to a degree of absolute certainty; rather, it is sufficient if each disputed requirement has been proven by a preponderance of evidence. *See id.*

A. Plaintiffs Propose Revised Class Definitions and Subclasses That Are Appropriate for Certification Under Rule 23

As set forth *supra*, Plaintiffs have re-defined the Classes and utilized subclasses to address the Court's concerns about commonality and typicality (*c.f.* CC Order at 10-12), excluding from the definition insureds who never submitted CLS claims and whose CLS claim included one of HCSC's Procedure Codes.

With the focused class definitions, Plaintiffs present a direct challenge to the "systemwide" HCSC Policy that governed HCSC's decision to impose cost-sharing specifically on: (a) the out-of-network CLS claims, and (b) any submitted CLS claim that did not include one of HCSC's Procedure Codes. *See A.F.*, 300 F.R.D. at 477, 481 (certifying a class of persons who were denied treatment based on a plan exclusion of a particular treatment for autism because, among other reasons, "all class members have in common the issue of whether the [exclusion] violates state or federal law").

Therefore, the class definitions, class membership, and the relief sought are tailored specifically to the resolution of the question of whether HCSC's Policy, in two respects, violated the ACA mandate for coverage without cost-sharing; those are two significant questions that drive the resolution of the Class' claims. *Wal-Mart*, 564 U.S. at 350.

In fact, even "[i]n circumstances [ ] involving minor overbreadth problems that do not call into question the validity of the class as a whole, the better course is not to deny class certification entirely but to amend the class definition as needed to correct for the overbreadth." *Messner*, 669 F.3d at 826 n. 15. Indeed in *Mitchell v. LVNV Funding, LLC*, No. 2:12-CV-523-TLS, 2015 U.S. Dist. LEXIS 152013, at *23-24 (N.D. Ind. Nov. 10, 2015), the court recognized that if necessary, it could create subclasses to address the difference between those consumers who are able to recover actual damages and those who are entitled to statutory damages

only, but that regardless "[a]djudicating the legal issue—whether the letters violate the FDCPA—will significantly advance the litigation and achieve economies of time and expense." *Id.*

Furthermore, as set forth *supra*, each Plaintiff was subjected to the harms alleged (had out-of-network CLS claims and their claims did not include one of HCSC's Procedure Codes), and, therefore, they are appropriate class representatives for each Class and subclass. *Dawson v. Great Lakes Educ. Loan Servs.*, 327 F.R.D. 637, 640-41 (W.D. Wis. 2018) ("Because Dawson alleges that Great Lakes subjected her to all three kinds of errors, she may serve as the class representative for each subclass"). The Classes are defined clearly, using objective criteria, and satisfy Rule 23. *See id.* at 644.

B. <u>The Proposed Classes Meet the Requirements of Rule 23(a)</u>

The threshold questions under Rule 23 are whether "(1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to each class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of each class; and (4) the representative parties will fairly and adequately protect the interests of each class." Fed. R. Civ. P. 23(a).

1. The Numerosity Requirement is Satisfied

Plaintiffs need not identify each and every potential class member or specify the exact number of potential members to demonstrate numerosity; a sensible estimate suffices. *Phipps v. Sheriff of Cook County*, 249 F.R.D. 298, 300 (N.D. Ill. 2008) ("Plaintiffs are not required to allege the exact number or identity of the class members and [the court is] permitted to make common sense assumptions in order to find support for numerosity."). Class members are identifiable from HSCS's Claims Data which contain thousands of CLS claims at issue, representing thousands of unique individuals who wrongly incurred costs for a CLS claim.

2. The Case and Revised Classes Present Common Questions of Fact and Law

To meet Fed. R. Civ. P. 23(a)(2)'s commonality requirement, even a single common question or a "common contention" of law or fact will do. *Beley v. City of Chicago*, No. 12-c-9714, 2015 U.S. Dist. LEXIS 163919, at *10 (N.D. Ill. Dec. 7, 2015); *see also Wal-Mart*, 564 U.S. at 350.[18]

HCSC's Policy states that CLS services are only eligible for coverage without cost-sharing when provided by a network provider and billed with a limited number of "procedure codes." Plaintiffs' claim is that HCSC's Policy does not comport with the ACA requirement that, for each member of the Classes, HCSC was to at "a minimum" provide coverage for and not impose any cost sharing requirements for CLS (*see* 42 U.S.C. § 300gg-13(a)(4)). HCSC's Policy, as written, does not comply with the ACA because it limits CLS no-cost coverage eligibility to: (i) in-network CLS claims and (ii) a restricted number of Procedure Codes. HCSC's Policy applied to each CLS claim submitted by each member of the Classes throughout the Class Period. With the focused class definitions, Plaintiffs now present a direct challenge to the "systemwide" HCSC Policy that governed HCSC's decision to impose cost-sharing specifically on: (a) the out-of-network CLS claims, and (b) any submitted CLS claim that did not include one of HCSC's Procedure Codes.

Indeed, as the Court's Class Certification Order recognized, at 9, "Plaintiffs legal theory ostensibly presents a potential classwide practice capable of generating a common answer….And courts have found commonality based upon such systemwide practices" citing to *Holmes v.*

[18] "While the Rule is phrased in terms of questions, what matters for class certification is the capacity of a classwide proceeding to generate common *answers* apt to drive the resolution of the litigation." *Beley*, 2015 U.S. Dist. LEXIS 163919, at *10 (citations omitted). It need not resolve every issue in the case (*Phillips*, 828 F.3d at 551), but the "common contention" will "be of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350.

Godinez, 311 F.R.D. 177, 217-20 (N.D. Ill. 2015); and, *A.F.*, 300 F.R.D. at 481 (finding commonality for proposed class of insureds claiming the defendant's group health plans illegally denied coverage to individuals seeking Applied Behavior Analysis despite the fact that the defendant may have properly denied some individual claims). In addition, the Court's Class Certification Order at 9 recognized that "Plaintiffs' theory that Defendants violate the ACA by employing overly restrictive coding to CLS [ ] could generate classwide answers to the question of whether Defendants comply with the ACA" (citing *Wit*, 317 F.R.D. at 127).

Plaintiffs are advancing two standard conducts of practice that affect the Classes, warranting a finding of commonality. Where a plaintiff presents evidence that a defendant has engaged in standardized conduct with respect to putative class members, the legality of which is an "outcome determinative issue," commonality is satisfied. *Healy v. IBEW, Local Union No. 134*, 296 F.R.D. 587, 592 (N.D. Ill. 2013).[19] Any argument by HCSC that factual variations in class members' situations would defeat commonality would be misplaced. *See e.g. Holmes v. Godinez,* 311 F.R.D. 177, 220 (N.D. Ill. 2015) ("Despite factual variations in putative class members' situations, Plaintiffs' allegations regarding [Illinois Department of Corrections'] system-wide failures [of failing to provide hearing accommodations to inmates] are the 'glue' that ties their [ADA] claims together."). Indeed, the Seventh Circuit has upheld commonality findings in analogous circumstances. *See e.g., id.* (rejecting defendant's argument that plaintiffs' claims challenged hundreds of individual decisions regarding inmate hearing accommodations, finding that "[Plaintiffs'] complaint principally attacks IDOC's system-wide policies… [and] common issues bind the Plaintiffs' claims together if IDOC's high level policies and practices do not

[19] *See Flanagan v. Allstate Ins. Co.*, 242 F.R.D. 421, 428 (N.D. Ill. 2007) (finding, in ERISA and breach of fiduciary duty action, "our courts have often found a common nucleus of operative facts when the defendants are, as here, alleged to have directed standardized conduct toward the [class]").

conform to the law").

Even if individual issues remain, they can be resolved, if necessary, after the determination of Defendants' liability. *In re Synthroid Marketing Litigation*, 188 F.R.D. 295, 301 (N.D. Ill. 1999)("If an individualized determination of proximate cause or damages becomes necessary, such questions can be resolved after the liability issue is decided. . . ."); *Johnson v. Aronson Furniture Co.*, 1998 U.S. Dist. LEXIS 14454, at *23 (N.D. Ill. 1998)("Individual questions of injury may be resolved after the determination of the common questions."); *Sterling v. Velsicol Chemical Corp.*, 855 F.2d 1188, 1197 (6th Cir. 1988)("The mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible."). Further, to the extent any differences within the class should later appear to be at the level of antagonism, the court can consider redefining the class or subclasses. *See, e.g., Spellan v. Bd. of Educ. for Dist. 111*, No. 91 C 5123, 1992 U.S. Dist. LEXIS 5779, at *7 (N.D. Ill. Apr. 24, 1992) (citing Wright, Miller & Kane, § 1775 at 457).

The challenged HCSC Policy as it exists and as altered by any judgment - including with respect to the billing codes - governs coverage for every CLS claim. The billing codes for CLS apply classwide. HCSC's coding policy for CLS (like any other covered service) does not and could not hinge on an individual class member's circumstance.[20] Commonality is satisfied.

[20] Where a plaintiff presents evidence that a defendant has engaged in standardized conduct with respect to putative class members, the legality of which is an "outcome determinative issue," commonality is satisfied. *Healy v. IBEW, Local Union No. 134*, 296 F.R.D. 587, 592 (N.D. Ill. 2013); *see also Stafford v. Carter*, 2018 U.S. Dist. LEXIS 34266, at *13-17 (S.D. Ind. Mar. 2, 2018) (rejecting defendants' arguments that "whether a particular individual is receiving a standard of care treatment for their medical conditions is an individualized inquiry," instead finding that common questions arise out of defendants' standard of care, whether plaintiffs had been denied certain treatments, and whether such denial caused injury).

3. The Named Plaintiffs' Claims are Typical of the Claims of the Classes

"The question of typicality in Rule 23(a)(3) is closely related to the preceding question of commonality." *Rosario v. Livaditis*, 963 F.2d 1013, 1018 (7th Cir. 1992). Named Plaintiffs' claims here are "typical" because they (i) arise "from the same event or practice or course of conduct that gives rise the claims of the other class members" and/or (ii) are "based on the same legal theory." *Id.* "Typical does not mean identical." *Gaspar v. Linvatec Corp.*, 167 F.R.D. 51, 57 (N.D. Ill. 1996). "Factual distinctions can exist between the named Plaintiffs' claims and other class members' claims, but the claims must share the same essential characteristics." *Magpayo*, 2018 U.S. Dist. LEXIS 26282, at *32 (quotation omitted).

Plaintiffs satisfy both alternative constructs of typicality. Under the revised Class definitions and class membership construct (as well as the relief, discussed *supra*), Plaintiffs' claims are, like the members of the Classes and Subclasses, tailored specifically to the resolution of the question of whether HCSC's Policy, in two respects, violated the ACA mandate for coverage without cost-sharing. Those two significant questions drive the resolution of the Class' claims.[21]

4. Plaintiffs and Counsel Are Adequate Representatives

To satisfy Rule 23(a)(4)'s adequacy requirement, Plaintiffs must show that they "will fairly and adequately protect the class's interests." *Id.* at *33-34. The "adequacy" requirement is satisfied so long as Plaintiffs have (a) no antagonistic or conflicting claims with other members of the class,

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[21] No "individualized issue" that HCSC is certain to conjure up, such as any "need" for individual medical record review, or varying payment amounts incurred by class members, even if accurate, precludes certification. *See e.g. Ries v. Humana Health Plan*, 1997 U.S. Dist. LEXIS 4035, at *27 (N.D. Ill. Mar. 31, 1997) (rejecting defendants' arguments that individual issues of the various plaintiffs would overshadow common questions where "[t]he overwhelmingly predominant issue in this case [was] whether defendants' [ ] procedures … violate ERISA"); *Ormond v. Anthem, Inc.*, 2009 U.S. Dist. LEXIS 90837, at *40-41 (S.D. Ind. Sept. 29, 2009) (rejecting defendants' contention that plaintiffs' class would require a "plan-by-plan evaluation" because defendants acted "across the board, not on a plan-by-plan basis" and the plaintiffs' claims were based on defendants' documents and state law, not "on the health insurance coverage under specific policies," certifying subclass of participants in ERISA benefit plans).

(b) an interest in the outcome of the case to ensure vigorous advocacy, and (c) qualified and competent counsel. *See id.* at *34.[22] Under the revised Classes, the Plaintiffs, like members of the respective Subclasses, share an interest in establishing that HCSC's Policy that governed HCSC's decision to impose cost-sharing specifically on (a) the out-of-network CLS claims, and (b) any submitted CLS claim that did not include one of HCSC's Procedure Codes, violated the ACA. They seek a common finding of liability and common, consistent relief including to have HCSC's CLS Policy declared void and in violation of the ACA since August 2012, and to enjoin its use. *See* Section III, *supra.* Plaintiffs' interests are aligned with those of the members of their respectively proposed Classes.[23]

Also, each Plaintiff has been actively involved in each phase of this litigation and will continue to vigorously represent the interests of the Class members going forward. Plaintiffs Adams, Briscoe and Magierski each:

- responded to 33 document requests and produced hundreds of pages of documents, including their and their children's medical records;
- responded to 17 interrogatories; and,
- took two days to prepare for and provide deposition testimony.

Further, Plaintiffs propose Chimicles Schwartz Kriner & Donaldson-Smith LLP be appointed as Class Counsel pursuant to Rules 23(a)(4) and 23(g).[24] Proposed Class Counsel is

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[22] *See also* 1 William Rubenstein et al., *Newberg on Class Actions* § 3:58 at 341-42 (5th ed. 2011) (explaining that only "fundamental" conflicts that "go to the heart of the litigation" render a class representative inadequate).

[23] Factual differences between named plaintiffs and class members do not defeat adequacy. *See Walker v. Bankers Life & Cas. Co.*, No. 06-cv-6906, 2007 U.S. Dist. LEXIS 73502, at *16 (N.D. Ill. Oct. 1, 2007) (regardless of whether the particulars of plaintiff's situation differed from those of other class members, the court found her adequate to represent the interests of the class) (citing *Duffin v. Exelon Corp.*, No. 06-cv-1382, 2007 U.S. Dist. LEXIS 19683 (N.D. Ill. Mar. 19, 2007) (Conlon, J.) (citations omitted) (finding adequacy even though factual differences existed)).

[24] Under Rule 23(g), courts consider: (1) the work counsel has performed in identifying the potential class

experienced in prosecuting complex litigations and class actions in federal courts nationwide, are amply qualified to litigate this case, have successfully prosecuted numbers nationwide class actions, and will continue to commit the necessary resources to representing the Classes. *See* Ex. 24, Firm Resume.

C. The Proposed Classes Meet the Requirements of Rule 23(b)(1) and (b)(2)

Plaintiffs must also establish one of the requirements of Rule 23(b). *Magpayo*, 2018 U.S. Dist. LEXIS 26282, at *7. Here, Plaintiffs challenge HCSC's Policy, seeking injunctive and declaratory relief, and therefore certification under subsections (b)(1)(A) and (b)(2) is proper.

1. Rule 23(b)(1)(A)

Rule 23(b)(1)(A) authorizes certification where "prosecuting separate actions by or against individual class members would create a risk of…inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class." *See Neil v. Zell*, 275 F.R.D. 256, 267 (N.D. Ill. 2011)(ERISA action).[25]

HCSC insists that its CLS coverage complies with the ACA. HCSC argued previously that "the ACA allowed them to impose cost sharing for out-of-network services because their network has lactation counseling providers." 12/4/17 Order at 6. Discovery has affirmed HCSC's commitment to its unlawful position. If each person to whom HCSC denied coverage or imposed cost-sharing based on HCSC's Policy were to litigate an individual action, and if some courts were to find that HCSC's conduct violated the ACA, and others were to find no violation, such "varying

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claims; (2) class counsel's experience in handling complex litigation and class actions; (3) counsel's knowledge of the applicable law; and (4) the resources that class counsel will commit to representing the class.

[25] "Rule 23(b)(1)(A) is applicable whenever 'actions by or against a class provide a ready and fair means of achieving unitary adjudication.'" *Zielinski v. Pabst Brewing Co.*, No. 04-C-0385, 2005 U.S. Dist. LEXIS 36819, at *11 (E.D. Wis. Nov. 30, 2005) (citing Fed. R. Civ. P. 23 advisory committee's note).

adjudications would establish incompatible standards of conduct" for HCSC. *See Vill of Bedford Park v. Expedia, Inc. (WA)*, No. 13-C-5633, 2015 U.S. Dist. LEXIS 1012, at *26 (N.D. Ill. Jan. 6, 2015) ("Rule 23(b)(1)(A) takes in cases where the party is obliged by law to treat the members of the class alike…").

Further, the prospect of inconsistent declaratory and/or injunctive relief satisfies Rule 23(b)(1)(A). *See Mezyk v. U.S. Bank Pension Plan*, No. 09-cv-384, 2011 U.S. Dist. LEXIS 13857, at *28 (S.D. Ill. Feb. 11, 2011). Here, Plaintiffs and the members of the Classes are seeking declaratory and injunctive relief, discussed *supra*, Section III.[26] Plainly, pursuit of similar claims for systemic reform through multiple individual lawsuits would be inefficient, and create a very real risk that different courts might order divergent or even conflicting relief. Accordingly, to avoid such a result, the Classes should be certified pursuant to Rule 23(b)(1)(A). *See Robertson v. National Basketball Ass'n*, 556 F.2d 682, 685 (2d Cir. 1977) (Rule 23(b)(1) certification is proper where plaintiffs sought rule changes that would impact future members).

2. Rule 23(b)(2)

Certification of the Classes is also proper under Rule 23(b)(2) because HCSC has "acted or refused to act on grounds that apply generally to the [Classes], so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2); *Mezyk*, 2011 U.S. Dist. LEXIS 13857, at *28-29. Rule 23(b)(2) "does not require that

[26] "ERISA class actions are commonly certified under either or both subsections of 23(b)(1) because recovery for a breach of the fiduciary duty owed to an ERISA plan, as is the predominant claim here, will inure to the plan as a whole, and because defendant-fiduciaries are entitled to consistent rulings regarding operation of the plan." *Neil*, 275 F.R.D. at 267. Essentially, in an ERISA action in which relief is being sought on behalf of the plan as a whole (as it is here), a plaintiff's victory would necessarily settle the issue for all other prospective plaintiffs. *Id.* Courts have held that breach of fiduciary duty claims brought under ERISA, like the ERISA Plan Class claims, are paradigmatic examples of claims appropriate for certification as a Rule 23(b)(1) class. *Id.* Similarly, with respect to the Non-ERISA Plan Class claims, the breach of contract claim here is grounded in the health plans' requirements to provide ACA mandated CLS coverage.

all members of the class be aggrieved by the challenged conduct," but plaintiffs "must be able to demonstrate that the conduct or lack of it which is subject to challenge be premised on a ground that is applicable to the entire class, and that the entry of declaratory or injunctive relief would remove a barrier or impediment common to the class." *Kazarov v. Achim*, No. 02-cv-5097, 2003 U.S. Dist. LEXIS 22407, at *27 (N.D. Ill. Dec. 12, 2003) (citation omitted). Further, certification under Rule 23(b)(2) is particularly appropriate to vindicate alleged violations of statutory rights based on a uniform practice applied to numerous individuals. *See Rodriguez v. Vill. of Montgomery*, No. 08 C 1826, 2009 U.S. Dist. LEXIS 9166, at *13 (N.D. Ill. Feb. 9, 2009).[27]

"A single declaration that the policies and practices alleged violate federal law would be final and would provide relief to each class member equally." *Holmes v. Godinez*, 311 F.R.D. 177, 223 (N.D. Ill. 2015).[28] Accordingly, the relief requested is sufficient to certify the Class under Rule 23(b)(2). *See id.; see also, Johnson v. Meriter Health Servs. Emple. Ret. Plan*, 702 F.3d 364, 372 (7th Cir. 2012) (Seventh Circuit affirmed class certification under Rule 23(b)(2) where the relief sought included monetary damages to correct a past error in ERISA benefits, as well as an injunction to resolve the issue going forward).[29]

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[27] *See also N.B. v. Hamos*, 26 F. Supp. 3d 756, 774 (N.D. Ill. 2014) (where success on plaintiffs' claims would require policy modifications and such policy changes were generally applicable, and therefore would benefit all class members, certification under 23(b)(2) was appropriate).

[28] Further, like Rule 23(b)(1), Rule 23(b)(2) has been a frequent vehicle for certification of classes in ERISA actions, including actions involving allegations of breach of fiduciary duty, because injunctive and declaratory relief are appropriate where defendants act or fail to act on grounds that affect the plan as a whole. *See, e.g. Neil*, 275 F.R.D. at 269 (finding certification of a 23(b)(2) class appropriate in ERISA action because of the equitable relief sought and because the incidental damages sought could be calculated mechanically); *Smith v. Aon Corp.*, 238 F.R.D. 609, 618 (N.D. Ill. 2006) (plaintiffs satisfied the requirements of Rule 23(b)(2) where "[t]he alleged breaches of fiduciary duty [ ] have affected all of the Plan's participants and beneficiaries").

[29] "Several cases hold that certification of an ERISA claim is proper under Rule 23(b)(2) where monetary relief, in conjunction with injunctive relief, is sought." *Breedlove v. Tele-Trip Co.*, No. 91 C 5702, 1993 U.S. Dist. LEXIS 10278, at *25-26 (N.D. Ill. July 26, 1993) (citing *Morgan v. Laborers Pension Trust Fund*, 81 F.R.D. 669, 681 (N.D. Cal. 1979) ("Courts are not precluded from certifying a class under Rule 23(b) merely because plaintiffs have included a request for monetary damages in their complaint. Rather,

D. Rule 23(b)(3) and "Ascertainability"

Plaintiffs seek certification under Rule 23(b)(2), not Rule 23(b)(3). Rule 23(b)(3), in contrast to Rule 23(b)(2), contains predominance and superiority elements that may underly considerations of the ascertainability of class members. Rule 23(b)(2) does not require the same demonstration or finding as a prerequisite to certification.

Moreover, in any event, the possibility of including people in the classes who have not been injured by HCSC's conduct **does not** preclude class certification. *See Pella Corp. v. Saltzman*, 606 F.3d 391, 394 (7th Cir. 2010) (holding that the possibility of including people who have not been injured by defendant's conduct does not preclude class certification "because … facts bearing on their claims may be unknown").

Even if a demonstration of ascertainability were required, and it is not, the analysis must comport with the Seventh Circuit's (along with at least the Second, Sixth, Eighth and Ninth Circuits) refusal to adopt a heightened ascertainability requirement. *See e.g., Briseno*, 844 F.3d at 1123, 1126 (citing *Mullins*, 795 F.3d at 658, and stating that "[T]he language of Rule 23 does not impose a freestanding administrative feasibility prerequisite to class certification. Mindful of the Supreme Court's guidance, we decline to impose an additional hurdle into the class certification process delineated in the enacted Rule."); *see also, e.g., In re Petrobras Sec. Litig.*, 862 F.3d at 265.

Plaintiffs have set forth objective criteria on which class members will be identified: those who submitted a CLS claim to HCSC for which HCSC denied or imposed cost sharing, and

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'where the monetary relief sought is integrally related to and would directly flow from the injunctive or declaratory relief sought, 23(b)(2) status is appropriate.'"); *Jansen v. Greyhound Corp.*, 692 F. Supp. 1022, 1028 (N.D. Iowa 1986) (ERISA monetary relief for retroactive payment of welfare benefits will flow directly from declaratory and injunctive relief, and is secondary to the declaratory/injunctive relief requested)).

Plaintiffs have proposed a set of procedure and diagnoses codes that do encompass all CLS care. HCSC's argument is that Plaintiffs' codes were over-, not under-, inclusive. To be clear, Plaintiffs have identified the coding options that HCSC and its experts challenge; no one asserts there are other options (*c.f.* Order at 11). Ms. Peluso, an International Board Certified Lactation Consultant ("IBCLC") and owner of a billing company for lactation consultants, identifies procedure codes that reflect the provision of CLS that appropriately allows physician or non-physician providers to identify the actual CLS rendered by trained CLS providers. *See* Ex. 18, Report of Plaintiffs' Expert Nicole Peluso, at pgs. 3-4, 8-9, 12-16, 18-19, Ex. B thereto.[30] In addition, Dr. Hanley (an MD and IBCLC) identified diagnosis codes used by providers to indicate that their encounter with a patient was for CLS. *See* Ex. 21, Report of Plaintiffs' Expert Dr. Hanley, Dated May 2, 2019, at pgs. 12-20. Even HCSC's expert, [redacted]

HCSC, of course, argues that Plaintiffs too broadly define the benefit. However, such determination is ultimately a liability and merits issue that is to be resolved at summary judgment or trial. And, importantly, the adequacy or inadequacy of HCSC's billing codes – a merits argument – necessarily requires resolution on a classwide basis, to then be applied to the Class

[30] Among other things, Ms. Peluso aptly explained why HCSC's Procedure Codes do not comply with the ACA mandate. *Id.* at pgs. 18-19. For example, Ms. Peluso points out that limiting CLS coverage to procedure codes that refer to preventive counseling (99401-4, 99411, 99412) does not adequately cover the clinical exam that normally takes place at a lactation appointment. *Id.* at 19. Similarly unreflective of the scope and reality of CLS are HCSC's codes that refer only to certain home visits for established patients (99347-99350), which wrongly presumes an existing relationship between the provider and patient, when that circumstance does not exist for lactation consultations. *Id.* Further, as Ms. Peluso opines, CLS coverage policies that do not include codes to reflect the occurrence of a clinical exam (*e.g.* an office visit 99201-5, 99211-5, or home visit 99341-5, or hospital visit 99221-3, 99231-3), ignore the actual scope of lactation services being rendered and exclude coverage for CLS claims. *Id.*

members and the reformation of HCSC's Policy.

At bottom, arguments about breadth are red herrings. Plaintiffs have amply presented the starting point for identifying potential class members based on HCSC's records. *See, e.g., Practice Mgmt. Support Servs. v. Cirque Du Soleil, Inc.*, 301 F. Supp. 3d 840, 858 (N.D. Ill. 2018) (applying *Mullins*, 795 F.3d 654 and finding that affidavits could be submitted to establish class membership where there was "a starting point for identifying potential class members" based on defendants' records). *See also Kumar v. Salov N. Am. Corp.*, 2016 U.S. Dist. LEXIS 92374, at *6 (N.D. Cal. July 15, 2016) (finding class members ascertainable despite defendant's arguments that class members would have to self-identify and show "what they paid, where they purchased it, and how many times, plus whether they saw and were deceived" by a product's label). *See also, Whitney v. Khan*, 2019 U.S. Dist. LEXIS 38288, at *17 (N.D. Ill. Mar. 11, 2019) (finding class certification appropriate where potential class members could be identified based on objective data in medical records); *see also Rikos v. Procter & Gamble Co.*, 799 F.3d 497, 525-526 (6th Cir. 2015) (finding class ascertainable where it "can be discerned with reasonable accuracy using Defendants' electronic records…, though the process may require additional, even substantial, review of files") (emphasis omitted), *cert. denied*, 136 S. Ct. 1493, 194 L. Ed. 2d 597 (2016).

VI. CONCLUSION

Based on the foregoing, Plaintiffs respectfully request that the Court certify the proposed Classes and subclasses under Fed. R. Civ. P. 23(a) and (b)(1) and (b)(2).

DATED: February 14, 2020

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

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CERTIFICATE OF SERVICE

I, Kimberly M. Donaldson-Smith, an attorney, hereby certify that on February 14, 2020, I electronically filed a true and correct copy of the foregoing document with the Clerk of the Court using the CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

/s/ Kimberly M. Donaldson-Smith
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